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Original Communications.

ANATOMY
IN ITS
RELATIONS TO MEDICINE
AND
SURGERY.

By D. HAYES AGNEW, M. D.,
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No. 9.

CRANIAL REGION (continued.)—If the longitudinal sinus be laid open, its interior will exhibit fibrous ridges, little round bodies "*Pacchionian*," and numerous orifices along the sides, *veins of the pia mater*, all of which open into the sinus, directed obliquely forward.

Arachnoid and dura matral processes.—Let an incision be carried through the dura mater, entirely round, on a level with the section through the cranial bones, and then turn up towards the median line of the head, and two smooth, moist surfaces will appear, one united to and inseparable from the inner face of the dura mater, the other next the brain, and separated therefrom by the pia mater; this is the *arachnoid*, the second or serous membrane of the encephalon. Like all serous organs, it is a closed sac, and in consequence of its adhesion to the dura mater on one surface, the division of the latter necessarily opens its cavity. Its color, when healthy, is a dead white intermingled with the slightest possible leaden hue. If a knife be pushed down to and passed around the crista galli, the dura mater may be removed back, and with it one of its processes, the *falx cerebri*, drawn out from between the hemispheres of the brain, thus exposing the whole superior part of the remaining membranes. By lifting up the posterior portion of the cerebrum, another process can be seen—the *tentorium*. Extending from the occipital protuberance forwards to the extremities of the petrous portions of the temporal bones, and thus separating the cerebrum from the cerebellum.

Pia mater.—Beneath the arachnoid is the pia mater, the last of the three membranous investments. Its structure consists of blood vessels, united by delicate connective tissue, which, sinking down into the spaces between, and mounting over the convolutions of the brain, is most accurately modelled to the form of its periphery. The arachnoid, while it lies in contact with that portion of the pia mater over the convex or exposed surface of the convolutions, does not follow it into the anfractuosities or spaces between them. The space between the two membranes is the *sub-arachnoid space*, and is occupied by a fluid, the *sub-arachnoid* or *cerebro-spinal fluid*.

The veins of the pia mater are large, and possessed of extremely thin walls, and lie in that portion of the structure between the convolutions. They are the great feeders of the sinuses. The three membranes now enumerated, fibrous, serous, and vascular, are common both to the cerebral and spinal portions of the nerve axis; in other words, are continued from the cranial chamber, throughout the spinal canal.

Practical Remarks.—The ridges in the sinuses are natural, the Pacchionian bodies likewise, the last being only apparently within, encroaching upon the interior, by prolonging the separating structures before them. The

sinuses will sometimes be found empty, at other times distended with coagulated blood, determined, in a great measure, by the mode of dying.

The forward direction of the venous orifices being opposite to the moving current in the sinus, would seem to be unfavorable to the discharge of their contents. Why such a disposition of parts should exist, can only be understood by regarding the following considerations:

The brain requires, for the proper exercise of function, a certain amount of pressure, which is supplied partly by its blood, and partly by the cerebro-spinal fluid. The withdrawal of this is productive of giddiness, confusion of ideas, and even syncope. Again, the whole mass of the encephalon is subjected to two movements; one of which is *cardiac*, and consequent upon the wave of blood sent into the large trunks at its base and elsewhere; the other is *pulmonic*, and produced by respiration.

During inspiration, when the thoracic walls and pulmonic tissue are expanded, the venous blood in the upper part of the body runs rapidly toward the heart, but during expiration, when these parts are contracted, the vessels are subjected to pressure, and the downward currents necessarily arrested, the turgid condition of the veins of the neck seen to take place during this respiratory act is sufficiently demonstrative of the fact. When an individual takes a few rapid and deep inspirations, quickly succeeding each other, a dizziness of the head is experienced, by the draining influence of such acts upon the vessels of the brain. Apply these facts to the subject in question, and it would appear that during the cardiac movement or impulse, when the brain rises in order to gain room, the sides of the sinus must be pressed toward each other, (for the fixed nature of the falx major prevents, in a great measure, the lower part being carried to any extent upward,) which approximation considered in connexion with the oblique direction at which the veins enter it, will not only press out the blood from the sinus, but at the same time close the venous orifices, so as to prevent their discharging any blood for the moment. These acts being much more frequent than the respiratory, tend to counteract the extreme operations of the latter.

One or two examples may serve to illustrate the idea. An object of great terror suddenly confronts an individual, he starts back, and at the same time makes a sudden and profound inspiration, followed by a deadly pallor of the countenance, reels, and perhaps falls to the ground insensible. Here the deep inspiration has drained suddenly the vessels of the head, hence the paleness. If loss of consciousness does not follow, the heart immediately sets to work, and by increased activity endeavors to restore the lost pressure, by pumping blood rapidly into the encephalic vessels. Or, suppose a person falls from a height, or receives a blow upon the head, followed by insensibility, the respiration is reduced in frequency, the inspiratory part of the process being short, and the heart's action diminished in frequency also, by these means the vessels of the brain are kept moderately full, and therefore calculated to prevent a more dangerous degree of insensibility.

It should never be forgotten that there may be great disturbances of the intellectual functions from an absence as well as an excess of blood; and these disturbances often resemble each other so closely, as to make the differential diagnosis a matter not always easy, though exceedingly important to be ascertained, as the treatment appropriate to the two conditions is diametrically opposite.

As this blood pressure is influenced very much by gravity, there are certain precautions to be observed from this fact. A patient reduced by a protracted illness should not be placed suddenly in the sitting posture, as it may produce fainting, and even fatal consequences. In this view of the subject there are periods in the course of fevers attended with great debility, where the change of linen ought not to be too rigidly insisted upon; where even dirt becomes more tolerable than that change of position which is required for its removal. The same circumstance would indicate the propriety of placing the head low in

fainting, or after exhausting hemorrhages, or its elevation in inflammatory states of the intracranial contents.

The more rapidly the pressure is removed, the sooner will fainting be brought about. In consequence of the muscular relaxation which follows such a state, it is sometimes necessary to produce it to aid us in the reduction of luxated joints, or hernial tumors, where ether is not available. As the result is all we desire, the sooner it can be effected the better, and at the least expenditure of the vital fluid. We therefore call to our aid the effect of gravity, by directing the erect position, and making large orifices in the veins opened. Or again, there may be cases of disease where it becomes necessary to avoid fainting, and yet to abstract a large amount of the circulating fluid; as, for instance, in peritonitis, or in some cases of pneumonia; then the recumbent posture should be observed, the head low, and the opening in the vessel not too large. In sleep there is a condition of fulness in the vessels of the brain, brought about and maintained in a good measure by both the action of the heart, and the state of the respiration. The considerable period between the inspirations during this state can scarcely have escaped the notice of any observer.

The falx major or cerebri is often found deficient in certain parts, especially in old subjects. Hard masses, resembling bone, are also frequently attached to its structure. These are sometimes bone, but more commonly consist of a fibrous basis, with a deposit of some earthy constituents. The fact of the sinuses being between the laminæ of the dura mater, leaves them liable to be opened, especially the superior and lateral ones, by spiculæ of bones in fractures, or even by the trephine in the hands of a careless operator.

The close attachment of the arachnoid to the same membrane exposes it to violence from whatever may affect the latter. Inflammation of the arachnoid may be overlooked, unless caution be observed. No marked discoloration is to be expected, but simply spots of opacities from adherent lymph. The cavity of the arachnoid should in health only be moist; a collection of fluid constitutes *hydrocephalus externus*, rather a rare condition. Its relation to the periphery of the brain will explain the possibility of compression occurring when such an accumulation occurs.

Inflammation of the pia mater is the *true meningitis*, though the term in a more extended sense may express a similar condition of any of the membranes. Its vessels present such diverse appearances, that much caution should be observed in expressing a pathological condition. These are found in various degrees of congestion, depending sometimes on cardiac disease, atrophy of the brain, or intemperance. The influence of alcoholic stimuli when long used as in habitual drunkards, is seen in the varicose condition of its vessels, the result of over distension. When its structure is infiltrated with serum, it is *œdema*. *Tuberculosis* of the pia mater is common. Its vessels may be ruptured by blows producing an extravasation of blood, which will, from the loose connexions of the membrane, be more extensive than those occurring exterior to the dura mater. To evacuate a clot thus situated, requires a division of parts calculated to render the result exceedingly unfavorable.

The *sub-arachnoid fluid* situated between the arachnoid and the pia mater is supplied from the vessels of the latter; it is protective to the brain, and its quantity bears a certain proportion to the quality and amount of the blood circulating in the vessels of the encephalon.

Encephalon.—This consists of the cerebrum, cerebellum, pons varolii, and the medulla oblongata. The cerebrum consists of two halves (*hemispheres*) which are connected to each other at the bottom of the dividing fissure, by a commissural bond, the *corpus callosum*, beneath which are cavities, the cerebral *ventricles*. There are five of these, two *lateral*, a *third*, *fourth*, and *fifth*, all of which communicate with one another, (except the fifth, which is cut off by the development of the fornix,) and are lined by prolongations of the pia mater and arachnoid membranes. The two first ventricles contain large ganglionic masses of neurine, the *corpora striata*, and *thalami*.

ON MICROSCOPICAL DIAGNOSIS.

By GUSTAF VON DUEBEN.

Translated, with Annotations,

By Professor LOUIS BAUER, M. D.,

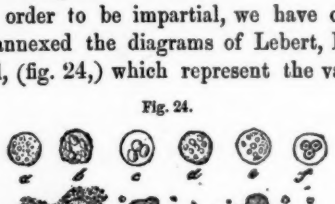
Member of the Royal College of Surgeons, England, etc., etc.

LUNGS AND SPUTA.—Under sputa we comprehend every secretion of the air passages and the respiratory organs raised by forcible expiration. As the sputa have to pass through the mouth, they may incidentally be the exponents of the normal and abnormal contents of that cavity. On examining the sputa, great care should be taken not to confound the microscopical elements of the two anatomical provinces.

The presence of pus, in the sputa especially, may give rise to doubts as to its origin in one or the other of these provinces. Having already and repeatedly adverted to pus as a microscopical constituent in various secretions, we may at this juncture enter more fully upon its microscopical considerations.

In order to be impartial, we have copied and annexed the diagrams of Lebert, Henle Vogel, (fig. 24,) which represent the various

Fig. 24.



phases and changes of the so-called pus-corpuscles. In comparing these with the mucous and white-blood corpuscles, (fig. 16, 20, *b*, 21,) irrespective of the variable number of nuclei and granules, we find no marked difference, they being all of from 0.004 to 0.010 mm. in size, more or less finely granulated, rarely without, mostly with from one to four nuclei, equally susceptible to acetic acid and other reagents, otherwise pale and of delicate organization. It is, therefore, quite impossible to discriminate one from the other in an object containing two kinds of these corpuscles.

The only basis of diagnosis is the number and locality from which they have been derived. Thus, for instance, in the sputa the number of mucous corpuscles is comparatively small and scattered. Abundance and conglomeration of corpuscles therefore indicate pus.

Of pus-corpuscles we can recognize two stages of development—the young cells, the corps-pyoides of Lebert, (fig. 24 *a*, *d*, *g*,) and the matured corpuscles, (fig. 24, *b*, *h*). In the former the formation of nuclei and granules is yet imperfect, and the liquid contents predominate; in the latter the corpuscles present themselves in an uneven surface, owing to their numerous nuclei and granules. These are the characteristic pus-corpuscles. They are, however, found under circumstances which do not admit of mistake. In pus derived from an abscess, or from copiously secreting mucous membranes, granules will be noticed that present dark contours and strongly refract light. Besides these, fat granules are sometimes visible. Both may be isolated, or comprised in the pus-corpuscles themselves. The presence of these elements may be considered additional proof of pus, except when they have passed the oral cavity, where such granules may exist as residues of food.

If the examination of sputa leaves no doubt as to the presence of pus, and furthermore, if the pus has not originated in the choanæ or the mouth, we may rationally infer that an inflammatory affection of the respiratory organ is going on. The microscope alone, however, cannot define the nature and the seat of the affection. But it is evident that microscopical examination will lend valuable assistance to ausculation and percussion in specifying the diagnosis. In some cases the microscope alone may render diagnosis easier, and indicate the character of the disease in the absence of other guides. Hence its paramount utility.

1. *Catarrhal affections of the respiratory organs.*

In either acute or chronic catarrh the expectoration comprises *pus*. In the former the sputa are thin, frothy, sticky, and mixed with small bluish lumps of gelatinous consistence.

As microscopical elements we find:

Pavement epithelium in different stages of development from the mouth.

Cylinder epithelium from the nasal cavity; occasionally *ciliated epithelium* from either the latter, the larynx or bronchi.

Oblong epithelium, from the finer branches of the bronchia and the lungs themselves.

Pus-corpuscles, mostly of recent formation, perfectly spherical, finely granulated, and through imbibition of fluid, rather larger than usual.

Exudation corpuscles.

Fibrinous particles and *fragments of the mucous membrane*, as presented under the head of pneumonic sputa.

Pickford states that he had seen pigment cells in catarrhal expectoration.

In chronic catarrh the sputa are now and then, as in the acute form, thin and frothy, but we notice an element highly characteristic, namely: small bluish-white or yellowish-gray lumps, exceedingly cohesive and viscid, adhering to the vessel, and, when immersed in water, sinking to the bottom.

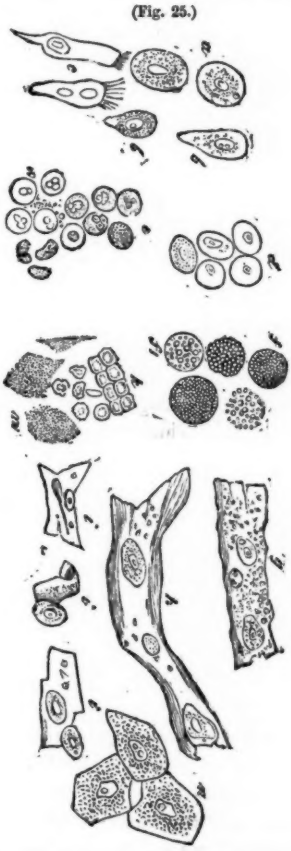
The microscopical forms characteristic of these sputa are about the same as enumerated, though with a decrease of pulmonary elements, and an increase of highly maturated pus-corpuscles and of fragments of bronchial mucous (basement) membrane.

Dr. Black* related the presence of urate of ammonia in the sputa of capillary bronchitis and rheumatism; of oxalate of ammonia in oxaluria; of cholestearine and biliphæine in teterus. Although these substances have no bearing upon the principal disease, yet they indicate the complication of the latter, and are therefore of semiotic interest.

2. *Croupous Affections of the Respiratory Organs.*—The chief characteristics of the sputa in genuine laryngo-tracheal or bronchial croup, are fragments of coagulated fibrine, variable in size, shape and firmness. This appearance is so conspicuous as to be readily recognized by the eye. Besides the pseudo-membranes the sputa have some elements in common with pneumonic sputa, which will now engage our attention.

Sputum Pneumonicum.—The microscopical elements in this sputum are of a diversified description, comprising the matured epithelium from the oral cavity, (fig. 20 *a*, 25 *n*,) *young epithelium* from the same place, round, not yet flattened, (fig. 25, *a*,) *cylindrical epitheluim* in great variety (fig. 25, *b*,) from the

(Fig. 25.)



choanæ and pharynx, not unlikely deprived of their cilia. (fig. 25, *c*.) This epithelium is not always as perfect as represented in the annexed diagram, but sometimes broken down, thereby increasing the number of granules in the pneumonic sputum.

Epithelium from the second layer of the bronchia below the ciliated cells. (fig. 25, *d*.)

* Monthly Journal of Medical Science, Edinburgh, vol. 16.

Their number in pneumonia, acute and chronic bronchitis, is almost incredible. When oval and less granulated, the larger cells can be easily discriminated from pus corpuscles, whereas the smaller ones, from the finer bronchial tubes, and especially when highly granulated, require the agency of acetic acid for discrimination, their nuclei showing themselves differently from those of pus corpuscles.

Pus corpuscles occur in all possible forms, large, small, transparent, with one or more and entirely without nuclei; dark, granulated, (à aspect framboisé—Lebert); shrivelled, etc. (fig. 25, *e*). The lower corpuscles of the group, after a longer submersion in distilled water, have been subject to the action of acetic acid.

Exudation corpuscles (fig. 25, *f*, inflammation corpuscles—Gluge.) These elements were first observed in inflamed tissues, but since also under other circumstances, from which it seems probable that they are either conglomeration of fat (proteine?) granules, or fatty degenerated cells of tissue concerned in the decay. Those found in the pneumonic sputum are, in all probability, the fatty degenerated epithelial cells from the bronchi.

* * * * * *

Fibrinous Particles (fig. 25, *g*, *h*,) consisting of cylindrical casts from the bronchial tubes, with embedded epithelial cells. The diagram (fig. 25, *g*,) represents an object removed from the mouth of a child suffering from capillary bronchitis; *h* from an adult on the fourth day of pneumonia. These casts occur in some sputa abundantly, in others, scantily, for which we are unable to account. The size of these casts is in proportion with the lumen of the bronchial tubes in which they originate.

Fragments of the Mucous Membrane—(Fig. 25, *i*.)—Although it is yet questionable whether fragments of the mucous membrane detach themselves and mix with the sputum of pneumonia, we have, nevertheless, observed rags and fragments which correspond so closely with the anatomical nature of the mucous membrane, as described by Black, and are so much at variance with the other microscopical constituents of pneumonic sputa, that we are disposed to admit them as particles of that structure. In the annexed diagram (fig. 25, *i*,) we have exemplified a specimen of the said description. It presents no granules as in the fibrinous casts; is flatter and more irregular in form. The sharp dots seem to be young nuclei. (Black.)

Red Blood Globules occur constantly and in large numbers in sputum cruentum. They are either isolated or joined to each other; in the latter case they are of irregular form, almost quadrangular; some crowded, shrivelled and partly decayed. (Fig. 25, *k*.)

Red Flakes (fig. 25, *m*,) minutely granulated, of variable and indefinite shape, consisting apparently of hæmatine.

All these form-elements are to be found in pneumonic sputum, however changeable in cohesion and density it otherwise might be.

We have purposely entered upon an extensive discussion on catarrhal and pneumonic sputa, in order to exemplify the direct utility of the microscope in defining both the extent and the nature of the disease and the structure affected.

In either bronchitis or pneumonia the physical signs are pretty reliable clinical guides. But in lobular and occult pneumonia the microscope is indispensable for early and correct diagnosis.

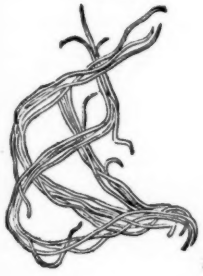
3. *Vomicæ and Tubercles.*—If a patient applies for professional advice, who has passed through pneumonia, whose physical signs conform with the anæmosis and the rational symptoms of progressive destruction of the lungs, the diagnosis is extremely easy and plain. Not so easy, by far, is the diagnostic discrimination of such cases in young individuals, where all clinical methods of investigation prove a chronic pulmonary catarrh *only*. And in these obscure cases Prof. Schroeder Van der Kolk has taught us to employ the microscope to advantage.

Strange enough, though evidently useful in differential diagnosis; the microscope has in this respect been totally ignored. According to our personal and extensive experience on this point, we can but affirm its high value in

obtaining positive results, where all other signs are of a mere negative character.

We know from pathological anatomy, that in pulmonary catarrh only the mucous membrane of the bronchial tubes, and that but partially becomes disintegrated. The same must be said of acute pneumonia on its resolution and return to health. In none of these cases can other form-elements be anticipated than those which strictly belong to the mucous membrane. And experience has confirmed this expectation. If, however, pneumonia assumes a chronic course, or suppuration has to perform the office of removing inflammatory obstruction in the parenchyma of the lungs, the disintegration goes beyond the mucous membrane, and the microscope reveals the morbid changes of all the structures involved. The same we notice in tuberculosis. In both eventualities we have expectoration, and find in the sputa the essential fragments of the bronchial tubes. Thus, for instance, in vomica we look for and meet with elastic fibrillæ in commensurate proportion to the size of the vomica; we indeed never missed them under such circumstances. We refer our readers to the diagrams (figs. 26, 27,) as good specimens.

(Fig. 26.)



(Fig. 27.)

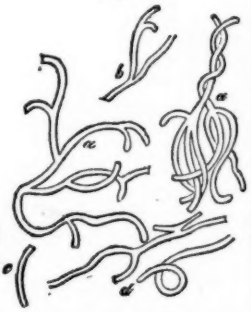


Figure 26 was taken from a patient, in 1850, an inmate of the Seraphinian Hospital of Stockholm. His case was set down as acute bronchitis, in which diagnosis all symptoms concurred. There were, however, elastic fibrillæ in the sputa, indicating incipient tuberculosis. Subsequent clinical observation has since verified the correctness of the diagnosis. Elastic fibres may be readily recognized by their regular, curved, dichotomic, equally wide, sharply contused anastomosing fibrillae, still more distinct under the action of acetic acid. *These fibrillæ are, therefore, the structural evidence of vomica;* their early discovery in dubious cases the basis of an early and correct diagnosis.

Incipient tuberculosis characterizes itself by a more or less chronic catarrh, its sputa, comprising a large number of pus-corpuscles, oblong and round epithelial cells of the second layer (fig. 23, *d*,) representing at the same time the peculiarities of sputa coeta. In taking, however, a small quantity of the paler portion of the lungs, and extending it very thinly on a glass slide, fragments of elastic fibrillæ will be found, with a power of 250. For obvious reasons we find the latter more readily in incipient than in advanced tuberculosis, because the disease is of less extent, and the catarrh restricted to the bronchial tubes nearest to the deposits. Both the morbid action and the bronchial secretion are limited. The small lumps then exhibit the elastic fibrillæ in the best, *i. e.* the least disintegrated condition, being at the same time of large size; whilst in the advanced disease the structural elements are broken up into small particles, and therefore less distinct and recognizable. Fig. 26, represents the elastic fibrillæ in tuberculosis of recent origin. Schroeder Van der Kolk, and the author have seen still larger fragments, so as to exceed the optic field of the microscope. Fig. 27 (*a a*) are forms observed in a later stage of tuberculosis, although scarcely in consummate phthisis. In this, as well as in vomica terminating chronic pneumonia, the elastic fibres in the sputa are much decayed,

Fig. 28.

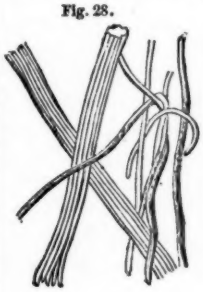
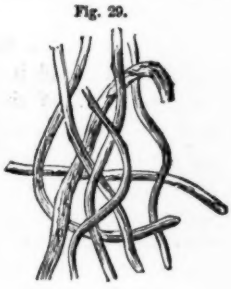


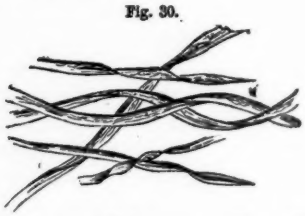
Fig. 29.



and therefore found and recognized with much more difficulty, (Fig 27, *b*, *c*, *d*.) Their diagnostic importance decreases, however, in reverse ratio, as the disease advances.

In order not to confound elastic fibres with the fibrillæ of linen, (fig. 28), silk, (fig. 29), or cotton, (fig. 30), their respective diagrams have been annexed.

Fig. 30.



4. *Gangræna Pulmonum.*—In well established cases of pulmonary gangrene, the history of physical symptoms, the characteristic quality of the sputa and the peculiar offensive odor of the latter, as well as of the breath of the patient, are reliable clinical guides for diagnosis. Sometimes, however, as, for instance, in inebriates, a simple bronchial catarrh or pneumonia may become associated with a fœtid breath and expectoration, indicative of gangrene of the lungs. And in other instances the sputa may become discolored, either accidentally or intentionally. In cases thus doubtful the microscope, discretely applied, will facilitate diagnosis. The sputa derived from this disease exhibit, under the microscope, the fragments of pulmonary structure, elastic fibres, particles of the mucous membrane, decayed epithelium, granulated cells, misformed pus-corpuscles, black and other granular and amorphous material. The elastic fibres in gangrene of the lung are usually very short, but numerous, so much so as to occupy almost the whole field of the microscope, (fig. 27, *c*).

5. *Accidental Elements in the Sputa.*—The class of accidental elements in the sputa is rather large and diversified. It comprises all sorts of foreign bodies, (fruit kernels and stones,) also calcareous concretions from obsolete tubercles, of which we have seen some in the form of minute corals. In this category belongs the case of Bennet, who found in the sputa, and subsequently in the caverns of a phthisical patient an alg, (penicikum glaucum ?) Frorieps Nolizen, 1843, vol. 33.

Again, the case related in vol. 104, page 160, of the same periodical, in which large quantities of red hair were expectorated, and, on post mortem examination, balls of the same material were found in the lungs, some of the size of a hen's egg. And finally, the cases of echinococci in either sputa or lungs, whither they had been carried with the matter of a hepatic abscess. These cases are, however, too exceptional to employ our time here.

Reduction of a Dislocation of the Humerus after Five Months, or One Hundred and and Forty-three Days.

By JOHN SWINBURNE, M. D.,
of Albany, N. Y.

June 28, 1859, Anson Ormsby, of Lewis county, N. Y., aged sixty years, entered the Albany City Hospital as a private patient.

Previous History.—On the ninth of February, 1859, twenty weeks and three days ago, patient dislocated the left humerus from the shoulder, by falling forward and striking upon the extended arm. He sought surgical aid, and an attempt was made at reduction on the same day. The operator believed he had succeeded in restoring the head of the bone to its socket and pronounced the joint perfect. Six weeks afterward the same physician confirmed his opinion, and volunteered to warrant complete success.

On the twenty-ninth of April, a period of eleven weeks and five days from the date of the accident, or eight weeks and three days ago, the same physician, after examination, decided that the shoulder was re-dislocated. Consequently, on the thirtieth of April, another attempt at reduction was made. Chloroform was employed, but according to patient's narration, in quantities insufficient to relax, but on the contrary to excite muscular contraction.

After laboring for three hours and a half, the operator desisted, being unsuccessful. Six weeks thence, or seventeen weeks and five days from the accident, tumefaction and inflammation having sufficiently subsided,

patient went to Brownville and also to Watertown, Jefferson county, for surgical advice. He was recommended by all to have no more attempts made at reduction, inasmuch as it was considered irremediable after so long a period of time.

Mr. Ormsby unwilling to despair of a cure, applied to me, and was admitted into the Hospital as above stated, on the twenty-eighth of June. The head of the humerus was found in the axilla, downwards and forwards.

On the following day, Drs. Bailey, Willard and Vanderpool, being present, patient was plied with chloroform until fully unconscious, and the reduction began. A band of calico was employed, folded three times to procure strength, and perforated through the middle by a hole sufficiently large to admit the arm and bear upon the axilla below and the acromion and coracoid processes above. With the heel in the axilla, we succeeded in destroying the adhesions, and extending the arm attempted to restore the head of the bone to its socket. After trying in this manner for about twenty-five minutes, the pulleys were adjusted and more extension made. The head of the bone was drawn outward and upward by a band adapted to the purpose, and the elbow then brought over the chest, when the head entered the glenoid cavity, but without the usual jerk, from the fact, probably, of the cavity being rendered unusually shallow by deposition. For the same reason, the head of the bone remained unusually prominent after the reduction of the dislocation.

The whole operation required three quarters of an hour, and was completed by placing a heavy compress in the axilla, and securing the arm with the elbow partly in front of the chest, by a sling and bandage. Patient was then placed in bed, and bladders filled with ice applied about the shoulder.

June 30. Patient rested moderately last night, and suffers no great amount of pain—swelling less than was anticipated.

July 1. During the night, patient by some means threw the head of the bone from its socket and reproduced the dislocation. This afternoon he was placed on the floor, and by extending the arm, and drawing outward and upward upon the upper extremity of the humerus, at the expiration of about ten minutes the head suddenly re-entered the glenoid cavity, this time with a sensible shock. The arm was then secured as before, and additional cautions prescribed to the patient. Ice-bladders applied around the joint.

July 2. Patient suffers but little pain, and is but slightly bruised. Joint in perfect position.

July 9. Arm in perfect position. The unusual prominence of the shoulder is rapidly disappearing, the head of the bone sinking deeper in its socket from the absorption of deposited matter. Patient has no pain, and there is scarcely any swelling or discoloration around the joint. Much caution used in keeping the arm perfectly secure, especially at night.

July 16. Arm in perfect position, and patient can easily move it in various directions. No deformity remains.

July 19. Patient discharged cured.

The length of time elapsing between the date of dislocation and that of reduction, being more than twenty weeks, is noticeable from the fact that dislocations are rarely considered reduceable after three months.

It is also worthy of notice that the deformity did not disappear immediately after reduction, as is always the case in recent dislocations.

Is it not possible that surgeons may be sometimes in error, in cases of long standing, from this circumstance; and that cases are sometimes abandoned as irremediable, because of the impossibility of restoring immediate symmetery; whereas by securing the parts as accurately and firmly as possible, the deformity may gradually pass away, as absorption of deposited matter progresses, and the head of the bone settles more and more accurately into its natural position?

A French Giantess, named Virginée Beauchamp, who is six feet five inches high, is now exhibiting herself in England.

Illustrations of Hospital Practice.

PENNSYLVANIA HOSPITAL.

JULY 16TH.

Service of Dr. Pancoast.

(Reported by Mr. J. B. Hayes.)

Railway Injury—Amputation of the Leg.—This was a case of injury of the lower extremities, which came in the night previous, and demanded an operation of some kind. The tarsal and meta-tarsal bones of one foot were broken and dislocated, and an extensive lacerated wound had bared the posterior half of the sole of the foot.

There had been a good deal of capillary oozing, but rather than irritate the parts by searching for the bleeding vessels, that admirable styptic, Moncel's salt—the persulphate of iron—had been used to stop the bleeding, and the foot had been left at rest.

After some remarks upon the different operations at or near the ankle joint, one of which would be performed if the case would admit, the patient was etherized, and Dr. P. proceeded to make a thorough investigation of the extent of the injury.

The finger could be carried through the wound in the sole into the ankle joint, and the destruction of the parts was found to be so extensive that it was deemed advisable to perform the ordinary operation upon the leg above the ankle. This was deemed the more necessary from the compound nature of the injury, as affecting both limbs.

The operation differed from the ordinary flap operation, inasmuch as the cut was made from within outwards. It was the operation which Dr. P. preferred in the leg. Two lateral flaps were cut, containing all the structures down to the bone, that on the inside being the longer. The flaps were retracted, so that the bones might be divided an inch above the incision in the skin. When brought down the flaps came together freely over the ends of the bones, which were left surrounded by their natural coverings.

The stump was to be left exposed to the air until all disposition to bleed had disappeared, and until it was polished over with a plasma of lymph, in accordance with a method long practiced in this house, and was to be very slightly encumbered with dressings.

The injury of the other foot demanded no operative interference.

Results of Treatment—Several Cases.—Dr. P. remarked that the patient to whose gangrenous stump the actual cautery had been applied, and who was before the class on the last day, was doing remarkably well.

He introduced the patient upon whose forearm it had been his intention to perform resection, if he had not been able to bend the callus. He had succeeded in removing the angular deformity of the *ulna*, by bending it, four days before. The compression kept up by splints had succeeded in restoring the fragments to their proper position.

Stump of Forearm Amputated by Teale's Method.—The case of amputation of forearm by Teale's method was exhibited to the class. It had done extremely well.

Mr. Teale dwells on the disadvantage of covering the stump with numerous heavy dressings. This has been covered very lightly, and has been lifted up from its bed of oil silk and cotton but once or twice in seven days.

The pus is allowed to flow freely out. In 24 hours the side sutures were taken away, according to Teale's direction. This is very proper. Sutures are often left in too long, keeping up an inflammatory action, which proceeds beyond the desirable effusion of plastic lymph.

The diet had been sustaining.

Dr. P. believed that there was great merit in this unirritating method of treating stumps.

Scrofulous Abscess of Face.—This is situated on the cheek, about the line of the crowns of the teeth of the lower jaw.

Its history is obscure. It presents the appearance of a scrofulous sore, and he has the marks of scars upon his neck.

This is not a dental fistula, with which, at first sight, it might be confounded. These occur most frequently about the base of the lower jaw, from a degenerative inflammation of the sockets of the teeth.

The probe is easily passed into a sinus an inch in extent, open at both extremities. The tissues covering the track of the probe must be laid open. The sinus is lined by an impure plasma, which cannot be restored to its original character.

The sinus was then laid open by a bistoury on a grooved director, and the degenerated plasma removed by scraping with the handle of a scalpel. The edges of ill-formed skin were snipped off by scissors.

JULY 20TH.

Progress of Cases.—Dr. P. remarked that he now considered the patient as out of danger whose arm was amputated two weeks ago. The skin flaps were lost by sloughing, but he would have a very excellent stump of the arm.

The young man whose leg you saw amputated

four days ago for a railway injury, never seemed to recover fully from the shock of the injury. On the succeeding day he was delirious, with a pulse of 130, hot skin and dry tongue. An extensive erysipelatous inflammation has been set up in the limb. Yesterday he improved, and to-day he is better, but I am by no means sure that he will recover.

In the case of this patient now before you—whose injury by mowing machine and the points in the treatment of which I dwelt upon a week ago—our attempt to save the leg has done extremely well. I think it has a fair chance of being successful.

We are a little apprehensive in regard to a chill which he had day before yesterday. Why should he have a chill? He has lived in a malarious district, but he has the appearance of robust health. When pyæmia sets in, it never occurs immediately after the operation. In one day you are not to expect it to follow; but if on the ninth or tenth day the patient has a decided chill, you are to be on the *qui vive*. Fortunately, 48 hours have elapsed without the recurrence of the chill, and the case is more hopeful from this circumstance. If pyæmia had set in properly, he should have a peculiar odor and a return of the chills.

He now takes the muriated tincture of iron, and quinine ten grains a day, with the most nutritious and stimulating food.

Hydrocele—Case 1st.—This patient was treated a week ago for the radical cure by injection with tincture of iodine.

The operation was followed, as we anticipated, by the rapid formation of a tumor, which has subsided, leaving the scrotum corrugated and nearly of its natural size.

In my large experience of this disease, I may say that I never knew it to recur after this mode of treatment. The whitish coating with which you see the scrotum covered is a deposit of the meconate of lead from the lead water and laudanum with which the tumor was kept moistened.

Case 2d.—This is complicated with syphilitic enlargement of the testicle. The test of transmitted light, however, clearly reveals a fluid here, but more at the back and side of the sac than usual; therefore I make the puncture here, in an unusual position.

A fluid tinged with blood runs from the canula when the trocar is withdrawn. The testicle is found to be twice or three times its natural size, and we can now detect adhesions between its anterior face and the sac.

This is what in olden times would be called a hydro-sarcocele, not myself meaning, however, by sarcocele a cancerous disorder, but a fleshy enlargement.

Dr. P. thought that the iodine injection, by its local action, had a tendency to promote absorption of tumors of the epididymis and testicle, and that it was especially indicated here. The solution he used deposited the metal in flakes upon the walls of the sac. He also cautioned the class against injecting with any irritating substance when the spermatic canal was congenitally pervious to the fluid, and referred to a mode of operating for hernia which he had successfully practiced 20 years before, and which he was disposed to resume, by injecting the hernial sac with stimulating solutions, using at the same time proper precautions to prevent their entrance into the cavity of the peritoneum.

The patient was directed to go to bed; and to to prevent dysuria, the ordinary house mixture, camphor water, spts. of mindererus, tartar emetic, and morphia would be given.

Operation for Removal of Internal Piles by the Ecraseur.—The subject of this complaint was a sailor, a class of men unusually liable to this disorder, their salt food disposing them to constipation.

After explaining the nature of this affection, defining the cases where operative interference is demanded, and describing the methods formerly much in vogue, and still in use, for the removal of piles, Dr. P. expressed his decided preference for the *ecraseur*, which, for its rapid execution, safety and comfort of the patient, possesses a decided superiority over every other instrument.

The mode of its operation was exhibited to the class in the removal of two internal piles of the size of a filbert. The patient was etherized, and two instruments were used conjointly. This Dr. P. considered much safer than the use of a single instrument, as the inventor practices, when the whole circumference of the gut is involved.

The Ecraseur acts by first compressing and then dividing the parts, leaving a cleanly cut surface much less in extent than the base of any tumor to which it may be applied. This surface is left to unite without any other application than simple dressings. It never bleeds, and the cure goes on rapidly.

The time occupied in this case, from the application of the ecraseur to the complete separation of the piles, was about 12 minutes. In general, the time depends on the vascularity, size, &c.. of the tumor.

A tube was introduced, to be kept in the rectum, and an injection ordered, containing 2 or 3 grains of the watery extract of opium.

DEFERRED CLINICS.

JUNE 8TH.

Service of Dr. Neill.

(Reported by Mr. J. B. Hayes.)

Swelling as a Symptom of Inflammation.—The 1st case is that of a man who has received a blow upon his face, which has produced certain symptoms, not so important in themselves, but serving to elucidate some principles of practical moment. There is no fracture, but great swelling and redness, attended with some inconvenience; he is unable to open his jaw.

I will direct your attention to swelling as one of the accompaniments of inflammation, a phenomenon which you see so often that you hardly attach the idea of its real nature to it.

This swelling has nothing characteristic in it; there is nothing in its appearance to determine whether it be permanent or temporary, injurious or reparative. There is nothing malignant in it; it is not cancerous, nor dependent on chronic disease—but on an injury. It is a local symptom of inflammation—a simple expression of inflammatory change.

Inflammation is exhibited by a variety of symptoms; there is no *single* characteristic. Swelling is not always present, nor can it always be manifested to the sight and touch. If this jaw were laid open, the tissues would be found infiltrated with serum and lymph; these to a great extent constitute the swellings that we meet in our experience.

The history of the lymph and serum—their changes and destination—is a subsequent matter; this patient will not show them all; and to elucidate them we must bring other patients before you. It is the object of this clinic to bring before you facts, and to deduce those generalizations from them which are usually called the principles of surgery.

Treatment.—By treating this swelling with cold water, it will entirely disappear, and illustrate that result which is technically termed *resolution*.

The 2d case is that of a boy with an injury of the head, which I showed you the last day. He received a blow from a piece of coal. I stated then that the character of swelling from injuries varied in the different tissues, and was modified by the subsequent changes in the material effused.

The scalp is underlaid by loose cellular tissue, and the characteristic of the swelling, or bump, as it is commonly called, is that the edges are abrupt and hard, and the central portion is soft, giving rise to the idea of an abscess or depressed bone. I then could not help thinking it a depressed fracture of the external table; although cautioning you at the same time against the deceptive feeling.

There is no cerebral disturbance. The swelling is softened and fluctuating. You can here see the changes which go on in the swelling, or rather in the materials which compose the swelling; it feels as if it were *pus*. Why, and how is this change effected? First, the swelling is caused by an effusion of lymph and serum, which are of the same essential constitution in all individuals, modified by individual types. How is it *lymph* one day, and *pus* the next? And where does the pus come from?

I will venture to say that none of you commenced the study of medicine with correct ideas of the formation of pus. I would say, in the first place, that suppuration has nothing to do with the flesh. Suppuration is never formed of the tissues.

Neither skin, nor cellular tissue, nor bone ever suppurates. This invariably, unalterably and universally is the result of the formation of lymph; there is no source under heaven other than lymph. The lymph may remain hard, or it may be converted into pus; as the corpuscles are more numerous in it, so is there more certainty of its conversion into pus.

This swelling has undergone a change; it may be broken down, and an abscess be formed. This is another of the results of inflammation. Here is a degenerative process, and the most common degeneration of lymph. This is not the only one; when effused upon the valves of the heart it may wither and become horny. In other portions, generally in the arteries, it passes into a calcareous degeneration. I have specimens of bone, apparently, taken from the diaphragm, and from the centre of the lungs.

Treatment.—The wound in this instance has been covered with a poultice.

The 3d patient has a peculiar ulceration of the sternum. I have shown so many forms of ulceration, and explained its nature so often, that it is not necessary now to speak of its nature in general. This particular form may not be uninstructive.

I have said that the term ulcer is applied to a healthy granulating surface. The appellations healthy or unhealthy, indolent or fungous are descriptive of the character of the granulations. In some cases ulcers involve the periosteum, and if we were to make another term, we would call it a periosteal ulcer; but terms are useful only so far as they convey ideas.

This form is slow to heal, and often obstinately refuses to heal; as it goes on, the bone becomes involved, and I have no doubt that the disease is often looked upon as caries, when the bone has become only secondarily involved. When cicatrization takes place, the skin will be consolidated with the periosteum.

Treatment.—Caustics and compression are absolutely necessary.

The 4th case presents great swelling and convexity of the tibia, anteriorly, with extensive ulceration.

This swelling, however, is not the result of the ulceration. He has had fracture of the leg, leaving great irregularity of the bone; and three weeks ago he scraped the skin over the tibia: this was followed by ulceration—the ordinary result of such an injury.

When ulceration occurs over a superficial bone, as in the sternum just exhibited, or in the tibia; when the health is not good, or the tissues involved are poor, the ejection and absorption—the ulceration in other words—goes on to such an extent that the periosteum becomes diseased, and is very slow in getting well. The cicatrix will be firmly consolidated with the bone beneath.

We here see a local symptom of inflammation—deep redness. It is of a purplish tint, denoting passive congestion. There is an enlargement of blood vessels which were small orginally. This appearance is apt to exhibit itself with old ulcers in defective tissues.

You can observe perspiration of the foot—a transudation caused by the obstruction of superficial vessels. This shows a certain state of nutrition and of the tissues. It is *perverted nutrition;* either an irregular supply of blood, or bad quality of the blood, a defective type of the tissues where it is deposited, or an imperfect state of the nervous force.

The Fifth Case is that of a negro with syphilitic periostitis. We have here no redness, but swelling and pain. Pain is a common expression of inflammation, and often exists alone as a sign of inflamtion, as in the nerves; here we cannot see either redness or swelling.

In this case of external periostitis, the swelling and pain are dependent on an exudation: if this is taken early, complete absorption may be produced. It may be disposed of in three ways—absorption, permanent deposit as bone, or suppuration. If acute periostitis, it may be absorbed; if constitutional, it may be deposited in a permanent form as a node; if traumatic, it may suppurate.

Now for his history: he has had chancres and bubo, and has taken a great deal of mercury. This fact shows that mercury does not prevent tertiary symptoms.

Lymph is apt to assume the type of its position; it has here become bone; but it never is converted into muscle or compound tissues.

Treatment.—We will give him no mercury. He will be benefited more essentially by iodide of potassium, an eliminative and not depressing remedy. He has been treated by this medicine, and the eruption you see on his face, following its use, is acne.

He has warm baths and a good diet.

Stumps.—Several patients were exhibited to show the changes which go on in stumps:

The First Case presents a stump of the finger. Changes have taken place in the end of the bone: it is rounded off and covered with periosteum, cellular tissue and skin.

Case Second was the lad injured by the rail car. (See REPORTER for May 7th.) For reasons given at the time of the operation, it was thought best to amputate only the first metatarsal bone with its phalanges.

The internal cuneiform bone is entirely rounded off, and the wound has nearly healed.

This case shows that nature is competent to do a great deal in young persons; and it is the height of medical science to know when she is competent and when she is not; and only to interfere when she is not.

He is about to be discharged.

Case Third.—Stump of arm. The operation was performed fifteen weeks ago. There has been exfoliation of the end of the bone, and the case has progressed slowly.

The saw tears the structures of the bone, breaks down the Haversian canals and the internal periosteum. In some instances a ring exfoliates—merely the corner of the outer edge; here a large piece has been detached from the end: its jagged serrations make it a difficult matter to extract it without tearing up the flaps to a considerable degree.

The exfoliation of bone after amputation, depends a great deal on the mode of treating the stump: the indiscriminate use of cold water is calculated to increase the number of stumps in which exfoliation occurs Cold water dressings depress the vitality of the parts, and are not to be used in the after treatment of amputations. In warm weather, and in vigorous constitutions, they may do well, but there is no particular advantage in them.

Case Fourth —Stump of thigh. This was a serious injury of the leg in a coal mine. The necessity for immediate amputation was obvious; but it was refused by the patient; and he was subsequently in a precarious condition. It became a matter of doubt whether the operation could be performed.

In performing secondary amputation it is a serious and responsible matter to determine the time when it shall be done—whether to-day or two days hence. The decision is to be influenced by the

state of the health, by constitutional excitement or depression, by the pulse, mental condition, state of the stomach, etc.

Where the integuments are infiltrated, as they were in this case, they will be suppurating in twelve hours. In such a state it takes very little while for the lymph to degenerate into pus.

Yeast poultices were applied, and every tonic and supportive food that the stomach could bear, was administered. The lymph became of a better kind, and the process of reparation commenced—the lymph-cells became tissue-cells.

Those who saw this stump, with its broad and open suppurating flaps, would hardly recognize it in its present contracted, cicatrizing condition.

Case Fifth.—The patient from whose back a benign tumor was removed twelve days ago, walked into the amphitheatre. A large portion had united; the rest is filling up by granulation.

Silver sutures were used; and broad strips of plaster, instead of a bandage, encompassing the chest.

Operation, Amputation of Last Phalanx of Thumb. This had been bitten by a squirrel, and ended in abscess and necrosis involving the joint: the distal phalanx had been already removed.

A flap was made from the palmar portion by slicing off the dorsal half. The degenerated synovial membrane was removed from the joint, and the edges were ordered to be kept wet for a while, without being brought together.

Reviews and Book Notices.

Transactions of Medical Societies.

(*Continued from p.* 345.)

In our last we were noticing the volume of transactions of the Medical Society of the State of New York. The next paper in regular order is on *Partial Dislocations—Consecutive and Muscular Affections of the Shoulder Joints*, by Alfred Mercer, M. D. Dr. Mercer shows in this paper the difficulties that the surgeon has often to contend with in dislocations, as they are sometimes caused by paralysis of some of the antagonizing muscles, which, by their combined action, maintain the head of the bone in place. He believes that a partial dislocation of a ball and socket joint—the muscles retaining their normal action—is an *impossibility*. The practical lesson deducible from this is, that a surgeon may have an action brought against him for malpractice, when, on account of paralysis of a portion of the muscles whose combined action maintains the bone in place, it was impossible, after its reduction had been accomplished, to prevent a re-dislocation of the bone. Dr. Mercer's propositions are well sustained by cases and by authorities.

Dr. C. E. Isaacs, of New York, reports an operation for the *removal of a tumor from the upper and posterior surface of the cranium* with a fatal result, the *post-mortem* revealing the fact that there was an encephaloid tumor of a large size (being full two inches in diameter) within the cranium, *completely obliterating the great longitudinal sinus for three inches and a half in extent.* The symptoms which this extensive disease of the brain gave rise to, were loss of vision in one eye, and impairment of that of the other, with chronic headaches of gradually increasing intensity.

Dr. Seth Shove, of Westchester county, reports two cases of *operation for congenital fissure of the soft palate*, which were creditably performed.

Dr. John Ball, of Brooklyn, reports a case of *hydrops sacci lachrymalis*, successfully operated on by him.

Dr. Edward H. Parker, of Poughkeepsie, furnishes an elaborate and well prepared paper on *the treatment of varicose ulcers.* The treatment proposed by Dr. Parker is the application of strips of adhesive plaster, *not* after Baynton's method, but after a method which he calls Critchett's, recommended by that gentleman in a course of lectures published in the *London Lancet* in 1848, (American reprint, Jan. and Feb. 1849.) By this method the whole limb, *from the toes up* to a point above the ulcer, or as high as the veins are enlarged, is smoothly and uniformly enclosed with strips of adhesive plaster from one to two inches in width. These strips should overlap each other about one-third of their width, and the ends should cross in front. There should be no chinks left uncovered by the plaster, and the ulcer or ulcers should be covered like all the rest. To apply these strips smoothly and uniformly is a pretty nice operation, and everything, moreover, depends upon it. After the plasters are put on, a bandage should be applied closely over them, from the toes to the knee, and the patient is sent about his ordinary occupations, even if they require him to stand all day. The dressing, in most cases, will have to be renewed in three or four days. We regret that our space will not allow us to give at length the directions for applying the plaster. We repeat, it is a nice operation,

and everything depends on the neatness of the application. Dr. Parker gives several cases in which he employed this mode of dressing successfully.

The next paper is an essay on *Scarlet Fever* by Dr. Henry A. Carrington, of Hyde Park, to whom was awarded a prize offered by the Society for the best essay on the subject. The essay, though it contains little, if anything, that is really new, is well written and methodically arranged, evincing on the part of the writer familiarity with the literature of his subject, and a practical knowledge of the disease. The treatment recommended by Dr. Carrington seems to be judicious and rational, much more so than is often met with in articles on this subject.

Dr. Alden March, of Albany, furnishes a paper, entitled *Ectopia Cordis, or Displacement of the Heart.* In recording a case that came under his observation in 1845, he takes occasion to give a synopsis of several other cases that have been published from time to time. He gives a minute description, accompanied by drawings, of the case that came under his own observation, though he had no opportunity of studying it until after the heart had ceased to beat. This paper was suggested by the case of M. Groux, with which many of our readers are probably familiar.

Next follows a paper on *Typhoid Pneumonia*, by Dr. John D. Watkins, of Sullivan county, and a *Sanitary Report* of Brookfield, Madison county, by Dr. A. L. Saunders, but neither time or space will allow an examination of them. Dr. J. V. P. Quackenbush, of Albany, and Dr. Daniel P. Bissell, of Utica, each furnishes a paper on *Inversion of the Uterus.* Dr. George Cooke, Superintendent of the Asylum for the Insane, at Canandaigua, furnishes a history and account of that institution. Dr. Sylvester D. Willard, of Albany, presents a paper on *Diphthérite*, as it prevailed in that city, and Dr. Howard Townsend gives a report on the use of the *Hypophosphites* in the treatment of tuberculosis. His experience and observation are not favorable to the pretensions of Dr. Churchill, who first proposed them. A case of *Facial Paralysis* is reported by Dr. Charles G. Bacon, of Oswego, with the treatment. Dr. Griffin Sweet, of Herkimer county, has a paper on *The Influence of Vegetation upon Animal Life and Health.* Dr. William C. Rogers, of Green Island, furnishes a paper on the *Registration of Diseases*, to which we propose to refer more at length on another occasion.

The remaining papers in this most interesting volume, and which we very much regret that we can only mention by title, are, *a Case of Rupture of a cul de sac of the Transverse Colon*, by Dr. Horace K. Willard, of Berne; a report of more than ordinary interest on the *Diseases of Saratoga county*, by Dr. James Lee, of Mechanicsville; one on the *Mortality of Brooklyn*, by Dr. Charles S. Goodrich; and one on *Vaccination*, by a committee, of which Dr. Wm. Taylor was chairman. Then follow one or two other reports, and the volume is closed by giving a synopsis of the unpublished Transactions of the Society, from 1807 to 1831, inclusive. This synopsis contains a great deal of very interesting and instructive matter, and it was well for the Society to embody it in their bound Transactions. Other State Medical Societies would do well to do the same thing.

In the above imperfect notice of the Transactions of the New York State Medical Society, we have given enough to show that it is a working Society, and that the results of its labors are creditable to the profession of the State, and beneficial to their brethren at large.

2. *Transactions of the Medical Society of New Jersey*, at its 93d annual meeting, held in the city of Trenton, on the 25th and 26th of January, 1859, pp. 95.*

We are very glad to see these Transactions published in pamphlet form. Until this year, since 1847, this journal was the vehicle through which the Medical Society of New Jersey published its transactions. The minutes of this meeting may be found in full in the REPORTER of Feb. 19th, p. 369.

The address of the President, Dr. I. P. Coleman, of Pemberton, on Medical Progress, is an able and interesting production, cursorily reviewing the progress which has been made in the different departments of medical science, and in the organization of the profession into societies, for the purpose of advancing the interests of the science.

We are very sorry to see that the reporters of nearly all the district societies failed to do their duty in respect to reports on the sanitary condition of the State—there being but two such reports, one from the Sussex, and the other from the Essex District Societies. These are very interesting, and that from Essex, which was drawn up by Dr. Lehlbach of New-

* We give the title page here as it *ought* to read, rather than as it stands.—EDS.

ark, is a very able report. This report contains several papers of more than ordinary interest. Interesting surgical cases are reported by Drs. G. Grant, A. N. Dougherty, and M. Baldwin, of Newark; and Drs. Cross, Dodd, E. A. Osborne, Lehlbach, S. Wickes, and M. Baldwin, report cases in medical practice. Dr. B. L. Dodd makes a valuable contribution in the shape of an *obstetrical report* of one hundred cases, under the following heads:—No. of case; Nativity (of mother?); No. of Pregnancy; Age; Presentation; Position and Variety; Hours in Attendance; Sex of Child; Length of Cord; Delivery of Placenta; Remarks; Result. The average length of the umbilical cord in 73 cases, was 23.859 inches. Of the 99 cases, 94 were vertex presentations. There was one face presentation, one case of twins, and two cases of placenta prævia. Dr. Wickes furnishes an interesting paper on the *Medical Topography* of the town of Orange, accompanied with a map. The *Vital Statistics of Newark*, by Drs. Woodhull, Grant and Lehlbach, form a very valuable part of this able report.

We close this notice by copying the following case of

Necrosis of the Upper and Lower Jaw, and Operation, by G. Grant, M. D., (with Lithographs.)

"Mrs. B., of this city, æt. 26, of good constitution, excellent health and physique, about the first of September, 1853, was attacked with intermittent fever, which usually prevails during the most of the year in that part of the city in which she resided. The history of the disease, in her case, did not differ from that of the ordinary course of the simpler varieties of periodical fever. Her medical attendant, during the course of the disease, administered a few grains of calomel, when in a very short time inflammation of the mucous membrane of the mouth occurred, which, extending through the subjacent tissues to the periosteum of the upper and lower jaw, resulted in necrosis of nearly the whole of these two bones, with consequent fœtid discharges, fistulous abscesses, etc. etc., followed after a time by a general cachectic condition of the system. This condition continued after the paroxysms of the fever had disappeared, and during the convalescence—a period of several months. In the early part of 1854 I was consulted by her, and on examination found that the disease involved nearly the whole of the upper jaw of the right side, with a considerable portion of the left side, together with a part of the lower jaw. The state of the patient at this time was indeed distressing; a foul sanious discharge impregnated her food as it was received into the mouth, and emitted an almost intolerable fetor. I advised the removal of the entire diseased portion of bone, to which, after several months' delay, she consented. A wash of dilute muriatic acid, in the course of a few days, entirely removed the offensive odor.

On the 12th August, assisted by Dr. M. Baldwin, I removed that portion of the upper jaw which was diseased. The incisions were made within the mouth, on either side of the bone, and carried up, until the characteristic feeling of resistance indicated the presence of hard living bone. The diseased portion was then pried off and removed. About a week subsequently I removed the diseased portion of the lower jaw, assisted by the same gentleman. The operation was performed in the same manner. Such was its extent, that upon detaching the bone it became necessary to saw it across in order to remove it from the mouth. There was little or no hemorrhage during or subsequent to either operation; and no anæsthetic agent was used to produce insensibility. The patient speedily rallied from the nervous shock, and in a few weeks had almost entirely regained her usual vigor and health.

This case I have thought was interesting, not only from the extent of the necrosis involving such an amount of the bony structure of the face, but from the circumstance that it had its origin during an attack of intermittent fever.

Calomel given at any time, it is well known, is a poison to patients of a certain idiosyncrasy, but such idiosyncracy could not be said to exist in my patient, inasmuch as both before and subsequent to the operation she had been under the influence of this agent (administered by different practitioners) without any injurious results. It was during the fever, and by a very few grains of the mineral, that its evil effect was manifested.

I think, therefore, it is a proper subject of inquiry, whether in intermittent fever there is not some contamination or dyscrasy of the blood, caused by the miasm, which, by predisposing the system to succumb more readily to the injurious action of certain remedies like calomel, favors the development of destructive inflammation in those tissues more especially which are the least highly organized, such as bones, for example. This depraved state of the system, induced by the melarious poison, is very evident in residents of the tropics,

where the intensity of the fever gives to all its symptoms a more marked character. From observations made during nearly a year's residence at Panama, I found this constantly and uniformly to be the fact. The fever is designated as *Calentura*, and differs from the intermittent fever of more temperate latitudes only in the greater intensity of all the symptoms, and the extraordinary anæmia attendant upon it. The blood seems to lose nearly all its coloring matter; the gums, lips and skin become dusky, dingy and pale. It is no unusual thing to find a single paroxysm followed by extreme debility, and even a typhoid condition.

Stanley, in his Treatise on Diseases of the Bones, p. 77, says: "I have seen[1] an instance of necrosis in nearly the whole body of the lower jaw, in case of fever, in which only a few grains of calomel had been administered; yet it was followed by excessive salivation and severe inflammation in the gums and cheeks."

Should the views here expressed be well-founded, their bearing on practice is obvious, suggesting the propriety of more than ordinary caution in the use of mercurials in malarious fevers.

[1] Museum of St. Bartholomew's Hospital, 1st Series, No. 102.

Editorial.

THE BANE OF MEDICAL JOURNALISM.

We have recently had occasion to announce the discontinuance of several medical journals. At least thirteen have ceased to exist within the past two years, and we believe that during our editorial career there has been no time when there have been so few journals in this country devoted to the interests of medicine, as now.

Medical journals are truly, as a valued cotemporary remarks, a short-lived race, in this country. Our readers can better judge how short, when we say that an editorial career of only nine years finds us the second oldest medical editor in the United States, our senior being Dr. Isaac Hays, the veteran editor of the *American Journal of the Medical Sciences*. Of course these frequent changes in the management of our medical journals, particularly in view of their cause, are greatly to the disadvantage of our medical periodical literature, and consequently of the profession at large, who should ever find it a reliable guide in the march of improvement.

There are two sources from whence medical journals must derive support, and without which their existenee will be but ephemeral, viz: original contributions of merit, and a *paid* subscription list sufficiently large to meet expenses, and yield something to pay the proprietors for their time and labor, and allow of some expenditure toward improving the journal by encouraging original research, and adding in other ways to its attractions. These two propositions, may, however, be reduced to the single one of an efficient pecuniary support, for money will command good material, and that will ensure subscribers. But again, to ensure permanence to the enterprise the money must come *from the subscribers*, for no school, publishing house or private individual, will be willing for any length of time to bear the expenses of keeping up a medical journal.

And this brings us to the point at which these remarks are aimed, viz. the *terms* on which our periodicals should be published. They all acknowledge the only principle on which they *can* be sustained, by announcing in their prospectuses that payment is required in advance; but unfortunately, in their anxiety to obtain "patrons" they fail to adhere to their terms, and in consequence, soon find that they are not meeting expenses, while on their books is a fearful array of unsettled accounts, which the sequel shews, are good for nothing. Having suffered heavily in this way while publishing the REPORTER in the Monthly form, we resolved, when we changed it to a Weekly, to make advance payments a *sine qua non* in conducting our enterprise, and we can assure our cotemporaries that we have found the plan to work admirably. We could increase our subscription list to an almost indefinite extent if we chose to depart from our terms, but believing that in the end the principle we have adopted will be better for both ourselves, our subscribers, and the profession at large, we

are determined to carry it out to the letter, and refuse our journal to those who do not see fit to comply with our terms. Our experience leads us to advise *all* our cotemporaries to adopt the same course.

The above remarks have been suggested by an editorial announcement of the thirteenth volume of the *Virginia Medical Journal*, in its July number. This we have looked upon, ever since its commencement, as one of the best medical journals in our country, and the "*Help me, Cassius, or I sink*" tone of the editorial remarks alluded to, pained us exceedingly. Will not the profession of Virginia, and of the whole South, rally to the support of this sterling journal, first, by settling off their old scores; and secondly, by increasing its circulation. How its "patrons" have treated it may be gathered from the following statement:

"The gross income of the Virginia Medical Journal has been six thousand dollars a year, nearly, for the past two years, and its cost of publication about twenty-five hundred dollars a year. With this apparently wide margin for profit, we have to tell our friends that the delinquent list, for two years only, amounts to *five thousand eight hundred and fifty dollars*,"—that is, so much money more than thrown away, as far as the interests of the editors and proprietors of the work, and the permanent interests of the profession are concerned! The true policy is to make our journals *worthy of support*, and *insist on advance payment*. Nothing short of that will make our medical periodical literature a credit to our country, profitable to our readers, and a source of income to its proprietors.

☞ Through the politeness of the publisher, Mr. John Wiley, of New York, we place before our readers this week, a chapter of the translation of Von Dueben's work on Microscopy, by Dr. Louis Bauer, of Brooklyn. This work, which will soon be issued, promises to be a most useful and desirable addition to our medical literature, as a practical text-book of Microscopical Diagnosis.

LITHOTOMY PER RECTUM.

This operation, a unique one, we believe, in this country, and which has been out of vogue for some years in Europe, was performed in Brooklyn on Monday, the 18th inst., by our friend and collaborator, Dr. Louis Bauer, of that city, in the presence of a number of surgeons. A calculus two inches in length, was extracted, and the incision closed by the silver suture —Dr. Sims performing this part of the operation.

A medical friend of this city, who saw the patient after the operation, informs us that no urine escaped by the wound at any time after its closure, notwithstanding the fact that by the misplacement of the catheter, urine accumulated in the bladder at one time to the amount of nine ounces. On Wednesday there were no blood or pus corpuscles in the urine, and on Thursday, urine was passed naturally for the first time, with four natural evacuations of the bladder on Friday.

The operation has, we are told, caused great excitement among the profession of New York, not among the least interested in its success being the venerable Dr. Valentine Mott. We learn, moreover, that some of the wiseacres of Bellevue Hospital have declared against it, *on the ground that Dr. Sims cannot always be present to apply the silver suture!* A detailed account of the operation is being prepared for publication in our pages.

THE NEW YORK MEDICAL GAZETTE.

This journal, which, "like a wounded snake, drags its weary length along," favors us with a "first rate notice" occasionally—that is to say, about once a month. Its last number containing rather more misrepresentations and misstatements respecting us than usual, we deem it worth while to notice one or two of them briefly. Our views in respect woman doctors, and the action of the Pennsylvania State Medical Society in regard to them, were stated so plainly and frankly, that there was no excuse for misrepresenting them, and we believe, as we stated, that they are in accordance with those of a large majority of the profes-

sion, *including* our friend, Dr. Jewell, who was *not*, therefore, the author of the article published in our pages in opposition to the views we had given expression to, which the *Gazette*, without the shadow of a reason, attributes to him. That article was written by a gentleman for whose opinions we have the greatest respect, even though we happen to differ with him on this question, and for whom the *Gazette* professes to entertain a high regard.

The fact is, the *Gazette* has got so into the habit of speaking detractingly of certain honorable members of the profession, that it often makes them responsible for opinions and practices, without the slightest ground for doing so. If its editor would devote but a small portion of the time he spends in misrepresenting the REPORTER, and in abusing Drs. Griscom, of New York, Jewell, of this city, and others, who are ornaments to their profession, to editing his journal, and procuring original communications for its pages, his few readers would be the gainers by it, and he himself would find it to "pay" in the long run.

Correspondence.

We are favored with the following extract from a letter from our countryman, Dr. E. D. Fenner, of New Orleans, to a professional friend in New York, having reference to a subject of much interest to American surgeons. It was of course not intended for publication, which is only permitted upon earnest solicitation:

MELROSE, SCOTLAND, *July 4th*, 1859.

MY DEAR ****.—You will doubtless be somewhat surprised at getting a letter written in sight of the celebrated old Melrose Abbey, and within three miles of Abbotsford, where once resided the "Great Wizard of the North."

But I heard something in Edinburgh this morning which afforded me so much pleasure that I cannot refrain from transmitting it while it is fresh in my memory.

I went to the Royal Infirmary to see the great surgeon, Mr. Syme, and the great obstetrician, Dr. Simpson, it being their clinical and operating day. A child with simple harelip was brought in to Mr. Syme. There were present some seventy-five or eighty spectators, nearly all medical students.

Mr. S. explained the nature of the case, what was necessary to be done, and the different methods of operating that were formerly pursued. He then took occasion to say that he was indebted to an American surgeon, Dr. Sims, for an improvement which had led to the *perfection* of this operation, as well as another, which in former days almost completely baffled the skill of the surgeon, but now seldom failed of success. He alluded to the operation for *vesico-vaginal fistula*.

The improvement was the introduction of the *silver suture*.

He said that another American surgeon, Dr. Bozeman, was over here last year, and claimed to have made a great improvement on Dr. Sims' operation, and was certainly very successful, but he (Syme) could not see that there was any improvement on Dr. Sims'. He said the whole merit consisted in the introduction of the *silver suture* and it was vain to attempt to deprive Dr. Sims of this honor. He said that another had attempted to show that there was nothing *novel* in the silver suture, but this proceeded from that captious and envious spirit unfortunately too often displayed in the introduction of every great improvement.

He went on to say that Europe was indebted to America for two of the greatest improvements in modern surgery—*anæsthetic agents* and the *silver suture*. Both were used on the case before him, and the operation was very neatly performed.

There were some five or six Americans in the room, and I assure you we felt quite proud of the compliment.

I understand Mr. Syme was at first rather prejudiced against the silver suture, and slow to adopt it, but you see he has the magnanimity to do the clever thing at present.

If I had time I could write you a great deal about physicians and surgeons over here, but I must refer you to my more elaborate letters that will appear from time to time in our [*New Orleans*] *Med. News and Hospital Gazette*.

After leaving Mr. Syme, I went to Dr. Simpson's lecture on ovarian dropsy. He is a fine looking man, and a fluent lecturer. After that I took the car for Melrose and Abbotsford, and here I am for the night and morning, but to-morrow night I shall sleep at old Stirling Castle, and thence to the lakes and highlands, whose romantic charms have been so admirably portrayed by Sir Walter Scott. I have mused at the graves of Shakspeare and Byron, Dryden, Milton, Pope, and Campbell,

and to-morrow I shall visit the grave and the late residence of the immortal Scott. From Scotland I shall go through Ireland back to London, thence to Paris, and thence—the Lord knows where. In all the large cities I make it a point to visit the medical institutions, and see as many of the great doctors and surgeons as I can. I thus try to combine improvement with pleasure. I expect to start back home on the 1st of October, intending to spend a day or two in New York and Philadelphia for the purpose of seeing the medical colleges in operation; and now, wishing you health and success, I remain, very truly, your friend,

E. D. FENNER.

[We are glad to have the opportunity of showing to our countrymen such distinguished foreign appreciation of one of the greatest modern additions to the armament of the surgeon, and to let them see that the credit is properly bestowed abroad, which at home some have been reluctant to yield.

It is not doubted, we believe, that various kinds of metallic sutures have been long ago employed, but it is very certain that their utility was not understood, and their general applicability was certainly not appreciated. To Dr. Sims alone must be awarded the credit of really setting forth to the world their value, and of illustrating it by an extensive application and extraordinary success in the treatment of conditions which had hitherto been almost abandoned as hopeless.

The true value of the metallic suture has been concealed by its frequent and useless complication with various ingenious devices in the shape of clamps, buttons, splints, etc., but those who have most used it, including the eminent gentlemen alluded to by Dr. Fenner, now rely on the naked suture alone, and with increased success.

The simple wire suture we believe to have been the element of success in the cases in which its merits have been masked by so many useless accompaniments.—EDS.]

The Castleton Medical College, of Vermont, has conferred the Hon. Degree of M. D. on Dr. S. N. Marsh, a "Radical Cure" Truss maker of New York. Is this an evidence of medical progress in our schools—or, have we been mistaken in classing Dr. M. with quacks, notwithstanding that he advertises extensively in some of the New York medical journals?

Periscope.

FOREIGN.

Medical Service on the Battle Field.—We (*Med. Times and Gazette*) make a few extracts from some interesting letters from the pen of M. Armand, attached to the ambulance of the 4th corps, now publishing in the *Gazette Médicale:*

The battle fought on the Ticino was hotly contested on both sides, and attended with great losses. Everything in our department was organized for acting *cito, citissime*, conformably to the urgency of the circumstances and the injunctions of Inspector Baron Larrey: "Proceed direct to the bridge, dress the wounded as rapidly as possible, so as to put them in a condition to be evacuated on the hospitals, and do not lose time in great operations, which may be deferred." Most of the injuries of the head only required simple dressings, for the reason that those which penetrated were usually fatal on the spot. Those of the face were accompanied by the most frightful injury, without affecting the intellectual faculties; the patients, indeed, coming themselves to have their wounds dressed. Wounds of the neck were also usually immediately fatal or comparatively slight. One of the prisoners had received a wound in the mouth with a sabre bayonet, which glanced off at the side of the jaw and came out at the lateral and upper part of the neck. There was hardly any loss of blood, and a simple suture at the commissure of the lips and a bandage were all that were required. Injuries of the upper extremities almost always, whatever their amount, allowed of the wounded repairing soon to the ambulances. Penetrating wounds of the chest and abdomen, usually so fatal, allowed in several instances their victims to survive for some time, usually to die, however, on their road to or soon after their arrival at the hospital. In some cases, however, vigorous reparative power of the economy, and a free use of antiphlogistic means, enabled recovery to take place. Injuries of the lower extremities were numerous, and the fractures were often comminuted. The rule was here, as in other cases, to extract accessible foreign bodies, arrest hemorrhage, and so to put up the part as to enable the patient to be carried to the hospital, where the question of amputation would have to be decided. The military surgeon is thus compelled to resort to much

temporizing surgery; and, for our part, we scarce know the case calling for immediate amputation on the field, except when some large projectile has carried away a limb with irremediable laceration. In such a case, even, the amputation need be immediate only when there is, which is rarely the case, dangerous hemorrhage; for in this case it is preferable to amputate, and tie the vessels regularly, than to apply a temporary ligature to the wounded vessel. When the amount of general stupor is such as to lead to the fear of fatal syncope during the operation, a provisional dressing only should be applied. As we too often saw in the Crimea, whatever we do under these circumstances, if the part injured be the leg, and still more the thigh, we shall rarely save life.

The armies now engaged both use the new fire-arms, the balls of which deviate far less after striking an object than the old spherical balls. We must, therefore, expect a larger proportion of comminuted fractures. Hollow and explosive projectiles being also proportionally more employed, the artillery fighting has become more murderous. Altogether we have, therefore, to expect a greater proportion of fatal cases among the wounded than heretofore.

After we had disencumbered our ambulances we carefully explored the field of battle, both to remove any wounded that still might have been left, and to direct the interments. There were but a few French still wanting succor, but a great number of wounded Austrians had been abandoned. The proof of the precipitancy of the retreat, or rather flight of the enemy, was the large number of wounded officers they left behind without any provision for their treatment.

While traversing the battle-field of Magenta, the saying which had formerly been current with respect to Russian soldiers, that they must not only be killed but thrown down, was brought to mind. A great number of the killed, in fact, retained in part the attitude they were in on receiving their death blow. Those who had died from injuries of the head usually fell with their face to the ground, and with complete resolution of the limbs. In those wounded in the heart, death, though rapid, is not so instantaneous that some attitude cannot be taken. A Zouave so struck had fallen on his musket, which he held in the position of a bayonet charge, his energetic face projected forwards with the menacing attitude of a dead lion. Not far off, as a contrast, lay an Austrian who had died of hemorrhage, and in his agony he had taken the attitude of supplicating heaven, his face turned upwards, and his two hands joined with fingers firmly interlaced. A Hungarian huzzar, killed at the same time as his horse, both being shot through the head, remained in his saddle, carrying the sabre forwards as during a charge. Some of the Austrian officers found among the slain, exhibited a distinguished physiognomy, and were dressed with exquisite, almost affected neatness and cleanliness, their features, very different from those of most of their soldiers, seeming to exhibit courage with resignation. Such were some of the impressions made upon us while traversing the field of battle, giving rise to painful emotions, little calculated to dissipate those produced by still more dreadful scenes within the ambulances, the receptacles of suffering of every kind. Physical fatigue is great indeed, but so also is the moral exhaustion of the surgeon, and great is the error of those who think his heart is hard, and that his impassibility is the result of indifference.

In our ambulances, calmness and resignation distinguished the wounded. To their honor, be it said, the soldiers with severe and often fatal wounds, restrained their complaints, and patiently awaited their turns. Groans and murmurs were rarely heard. The stoicism of courage, proud in its wounds, was the general rule. The railway to Milan, which the enemy had not had time to destroy, was of immense service in transporting the wounded to the hospitals of that city. (*To be continued.*)

AMERICAN.

Vaccination has now been tested by the experience of three-score years. The best informed and unprejudiced judges state the result as follows: "It affords complete protection to a very large majority of those subjected to its influence, and comparative protection and *almost complete exemption from death* by smallpox to all." In Sweden and Denmark, smallpox disappeared for twenty years under the depressive influence of compelled vaccination. Chance and the careless security engendered by an absence of the pest, led to its re-introduction, and in 1825 an epidemic occurred at Copenhagen, in which many who had been vaccinated were attacked, but only one of these died. In Geneva, Rouen, Anspach, and other large cities, where vaccination is rigidly enforced, smallpox is almost unknown. The surest test, perhaps, to which vaccination has been subjected, occurred at the terrible epi-

demic of Marseilles in 1828. The population of the city was 40,000; that is to say, 30,000 vaccinated, 8,000 unprotected, 2,000 protected by antecedent smallpox. Of the unprotected, half were attacked, and 1 in 4 died; of the vaccinated, 2,000 were attacked, and 20, or 1 in 100 died; of the variolated, 20 were attacked, and 4, or 1 in 5 died. When it is certain that vaccination has been properly performed, it gives better figures than this. Thus, in twenty years succeeding 1837, in the British army, there were 1,161,457 soldiers, many of them exposed to virulent epidemics in various climates. Less than one-fifteenth of one per cent. contracted smallpox, and that in a mild degree. In our own army, Dr. Porter says he has never heard of a case of smallpox. Thus, when vaccination fails to afford complete immunity, it still takes away the sting and peril of the variolous disease, except in rare instances.

Swinging Exercise in Pulmonary Disease.—*The Scientific American* copies the following excellent suggestion from a communication by Dr. Long, in the *Springfield Republican*. He says:

"I recommend the suspending of the body by the hands by means of a strong rope or chain, fastened to a beam at one end and at the other to a stick three feet long, convenient to grasp with the hands. The rope should be fastened to the centre of the stick, which should hang six or eight inches above the head. Let a person grasp this stick, with the hands two or three feet apart, and swing very moderately at first, perhaps only bear the weight, if very weak, and gradually increase as the muscles gain strength from the exercise, until it may be freely used from three to five times daily. The connection of the arms with the body (with the exception of the clavicle with the sternum or breast bone) being a muscular attachment to the ribs, the effect of this exercise is to elevate the ribs and enlarge the chest; and as nature allows no vacuum, the lungs expand to fill the cavity, increasing the volume of air, the natural purifier of blood, and preventing congestion or the deposit of tuberculous matter. I have prescribed the above for all cases of hemorrhage of the lungs and threatened consumption for 35 years, and have been able to increase the measure of the chest from two to four inches within a few months, and always with good results. But especially as a preventive I would recommend this exercise."

Medical News.

In the *Atlanta Medical and Surgical Journal*, Dr. O'Keefe gives an account of his medical visit to New York. In this journey he passed through Philadelphia, and lest he might see something of its medical greatness in the way of medical institutions and medical men, which might spoil his vision for a view of New York, he cautiously shut both his eyes, and on arriving in the latter city, put on a pair of rose-tinted magnifiers. The result is a brilliant display of New York medical notorieties, and a view of Philadelphia such as he might have obtained by passing through it in a long tunnel. Yet he conceitedly offers, from these observations, a comparative view of the medical merits of the two cities. The value of this comparison may be appreciated from the fact that of the numerous hospitals in this city, Dr. O'Keefe discovered but *two*, whilst in New York he found, he says, *twenty-five!* The Pennsylvania Hospital he entirely ignores, as it was probably much too large for the field of his microscopic vision. He says that the Blockley Hospital is an *almshouse*, and makes the absurd statement that hospital wards are only accessible to pupils of the attending physicians. The only Philadelphia medical name which attracted his special attention was that of Dr. McClintock!

He gives an extraordinary account of New York and its hospitals, and his investigations seem to have extended further than those of any previous explorer.

A New Epidemic.—A correspondent in Maryland, says:

"The only professional news that our neighborhood affords at this time, is, that we have had an extraordinary epidemic of *twins*. During the last five months, within an area of three or four miles, (in the country), where usually there is not more than one pair a year, we have had *thirteen pairs!* In some instances three or four pairs in the immediate vicinity of each other. This sudden increase in our local population is as unaccountable as extraordinary. Every patient now who is brought to the bed of labor, appears as naturally to expect twins as at other seasons their coming would surprise them."

The Military Hospitals at Milan number twenty-five and contain ten thousand patients.

The Impurity of the Thames.—The report of Dr. Letheby says: "The amount of ammoniacal vapor and of fetid gases evolved from the water, has been enormous: as much as fifteen cubic inches of the latter, and a grain and a half of the former have been obtained from a gallon of the water by simply heating it; and although the fetid gases do not contain a trace of sulphuretted hydrogen, they contain a putrid organic vapor, which is in the highest degree offensive. Last year the soluble organic matter in the Thames at high tide, ranged from ten to twenty grains per gallon, and the insoluble from half a grain to six grains. This year it has been from four to ten and a half grains, and the insoluble from half a grain to six grains. The condition of the river has not, therefore, reached its maximum of impurity. It was in its worst state in the week ending on the twenty-first of May, when the soluble organic matters amounted to rather more than seven grains per gallon. From that time until the week ending on the eleventh of June, it gradually improved, and the proportion of organic matter fell to about four grains per gallon; but since then it has been steadily increasing, and last week it contained more organic matter than I have yet seen in it. I expect, therefore, that when the final conditions of putrefaction are present, the river will again put on its most offensive appearance."

The *Lancet* says that eighteen million gallons of fluid sewage flow into the Thames every day. This contains six hundred tons of deposit, or two hundred tons of solid dry material.

The *Semi-Monthly Medical News* of Louisville, gives the following specimen of New York high-*pressure* puffing:

SENSATION ANSWERS TO CORRESPONDENTS.

P. G., Brussels.—The irregularities have been unavoidable. Our five-fly press will now strike off thirty thousand copies a second—printing, stitching, binding, and superscribing included. You need not be apprehensive for the future.

A. S., Montebello.—Thank you for your flattering opinion. We prefer the electric knife and fly wheel saw for amputation on the battle-field.

J. S., San Francisco.—The usual period of utero gestation is nine months.

A. G., Metz.—There is but one State in the Union, one city in the State, and one Medical College in the city. The University rooms can accommodate four thousand students.

M. R., San Antonia.—Our Journal is the only channel through which Professor Blow's inimitable lectures are allowed to flow into the world's sea. They will soon be dramatized.

R. V., Hoboken.—Cannot insert your communication. You have many journals in your own city. Select one of them.

A. F., London.—Yours, inclosing thirty dollars for ten years advance subscription, has been received and contents duly credited. Thank you for your appreciative benefaction.

T. S., Hamilton, Canada.—You are right in stating that our city stands pre-eminently predominant in medical literature, and that it is the "only city in America suited for medical teaching." There is an obscure but pretentious village in a State called, we believe, Pennsylvania, which has been aspiring to position in this respect, but its reputation is entirely local.

P. G., Surgeon-General in the Allied Army in Italy.—"Send 25 copies of your sine qua non to head-quarters. We might as well think of going to battle without ammunition as into surgical practice here without your indispensable journal." They shall be sent as desired. We are glad to find that our efforts to issue a journal worthy of this great and glorious country are appreciated in such ex alted quarters. Aut Cæsar aut nullus is our motto.

E. S., Panatomohœ, Miss.—Copies have been forwarded to your several students. They have determined wisely. The obstetric clinic alone offers one case every three minutes, and the sole charge of it has hitherto devolved on the erudite professor who conducts it. Such labor requires superhuman effort, and were it not that a Supreme Being for wise and beneficent purposes has sustained his giant physical and intellectual power, he would have long since fallen a victim to his love for the profession and devotion to medical students.

—— —, *Pawneeton, Iowa.*—Please write more legibly. We cannot decipher your initials, and will not, therefore, venture to insert what we suppose them to be. Some have already complained that none such as we have given are to be found in the places named, and some even assert that there are not such places in the State as we acknowledge receipts from. These complaints could not occur if our correspondents would write plainly.

Five dollars per number will be cheerfully

paid for any copies of our journal issued in 1857. The demand for them from new subscribers renders this offer imperative.

Foreign Honors.—Dr. S. D. Gross has received a diploma honoring him with the title of CORRESPONDING MEMBER OF THE IMPERIAL ACADEMY OF MEDICINE OF VIENNA.

Dr. Wilson Jewell has been appointed CORRESPONDING MEMBER OF THE IMPERIAL GEOLOGICAL STATE INSTITUTION OF VIENNA.

Another Floating Hospital.—The barge Pilgrim, which is now used in conveying patients to Ward's and Blackwell's islands, at New York, is about to be converted into a floating hospital. A deck is to be added, and the interior arranged for the reception of patients, the character of whose diseases is not fully determined. The board hospitals which were erected on Staten Island, after the fire, last season, are being demolished, and the repairs to the barge will be made with lumber taken from them.

The corner stone of the new Western Pennsylvania Insane Asylum, was laid on the Backhouse farm, near Pittsburgh, on the 19th inst. This institution is pleasantly located on the Ohio, on the line of the Pittsburgh, Fort Wayne and Chicago Railway.

In an appeal to the public for funds for the new Inebriate Asylum, at Binghampton, N. Y., the Directors say that they had at the time their appeal was drawn up received applications from—if our memory serves us rightly—nearly 3,000 persons, most of them from the upper walks of life, who desired to become inmates of the institution. Among these were nearly four hundred *women*, over forty *lawyers*, thirty-six *physicians*, and nearly thirty *clergymen!* A sad comment, indeed, on the prevailing customs in respect to the vending of intoxicating drinks! At this rate how many inebriate asylums will be requisite to supply all sections of our country while intoxicating drinks can be procured at thousands and tens of thousands of places throughout the land?

Harper's Weekly makes a display of "Uterine Catholicon" advertisements. Is this an evidence of its being a *Journal of Civilization?* It should tell its readers that the best uterine catholicon is *exercise* and *fresh air.*

The American Association for the Advancement of Science will hold its next meeting at Springfield, Mass., on the third of next month.

The American Dental Convention will hold its fifth annual session at Niagara Falls, commencing on Tuesday, the second day of August.

The Late Baron Humboldt became a pupil of Mr. Rarey, the American horse-tamer, and received instruction with a class formed for the purpose at Berlin.

A Death from Chloroform.—The *New York Medical Press* says that a death from inhalation of half an ounce of chloroform has occurred at the Bellevue Hospital.

At a meeting of the Board of Guardians of the Poor of this city, held on the 27th inst., the office of Chief Resident Physician at the Philadelphia Hospital was abolished. A board of twelve visiting physicians is to be appointed who are to serve without pay. It is probable that a Superintendent will be appointed to the charge of the lunatic department of the hospital.

Correction.—The types made us say last week, that Dr. John Bell, of this city, had been appointed to the *Charity* Hospital. It should have read *City* Hospital.

☞ Owing to accumulation of material, we have been compelled to add several pages extra to this number. We have still left on hand several original communications, besides other matter in type which was prepared for this week's issue.

TO CORRESPONDENTS.—*Dr. P., Hickory Grove, Miss.* Mr. Kolbé, surgical instrument maker of this city, will communicate with you in regard to a spinal apparatus, which seems to be indicated in the case you mention.

Dr. F., Darlington, Md. We have a complete set of the Charleston Medical Journal, but like it too well to part with it. You can get the 5th, 7th, 8th, and 9th Vols. of the Transactions of the American Medical Association collectively for $5. Other volumes can be obtained by permanent members for $2 each, except the fourth which is out of print, and the last published, which is always $3. The best way to get the fourth vol. would be to give the publishers, Blanchard & Lea, a standing order, for any copy they may accidentally procure.